

8571

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN 1b <u>24 Hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> <u>15x-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Edgewater Apts</u>				d. STREET ADDRESS <u>3511 Randolph Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTIE EARNST BARTZ</u>				4. DATE OF DEATH Month Day Year <u>July 12 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30 1908</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Month Days <u>11 12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer-Dept of Defense</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles H. BARTZ</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE LOOS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>		17. INFORMANT <u>Mrs Thelma Bartz</u> Address <u>3511 Randolph Rd Wheaton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Occlusion acute</u> DUE TO <u>Arterio-sclerotic CVD</u> Conditions, if any, which gave rise to immediate cause (b) <u>2 yrs</u> (c) <u>2 yrs</u> DUE TO <u>2 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Francis J. Townsend, Jr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANCIS J. TOWNSEND, JR</u>				DATE SIGNED <u>July 12, 59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUL 15 59</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Pumphrey</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please excuse the delay. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1071

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint, illegible handwriting.



8570

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Potomac, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SOLOMON CROPPER</u>		4. DATE OF DEATH <u>July 21, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Cropper</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Carr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Nellie Brittingham-Potomac</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 8, 1959</u> to <u>July 21, 1959</u> , that I last saw the deceased alive on <u>July 21, 1959</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. E. Crocker</u>		M.D. <u>Wm. Church Ch. 7-22-59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7-24-59</u>	<u>St. James</u>	<u>Potomac, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>		24a. REC'D BY REGISTRAR <u>JUL 27 59</u> DATE	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>William L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0570

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>	
<p>8. Signature of registrar: _____</p>	
<p>9. Signature of informant: _____</p>	
<p>10. Signature of witness: _____</p>	
<p>11. Signature of funeral director: _____</p>	
<p>12. Signature of undertaker: _____</p>	
<p>13. Signature of cemetery: _____</p>	
<p>14. Signature of burial: _____</p>	
<p>15. Signature of interment: _____</p>	
<p>16. Signature of cremation: _____</p>	
<p>17. Signature of other: _____</p>	
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8572

CERTIFICATE OF DEATH

118549

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN				c. LENGTH OF STAY IN 1b 25 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS MAIN ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANNIE Middle DAVIS Last DAVIS				4. DATE OF DEATH Month JULY Day 5 Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1, 1869		9. AGE (In years last birthday) 90 Yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME HARRY WALTERS				14. MOTHER'S MAIDEN NAME EMMA ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT BERLIN NURSING HOME Address BERLIN MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) High Hypertension & DUE TO (c) Arteriosclerosis & heart Chr.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-23, 1959 , to 7-5, 1959 that I last saw the deceased alive on 7-4, 1959 , and that death occurred at 9:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Chas R. Law M.D.				ADDRESS (Street, city or town, state) Berlin Md. DATE SIGNED 7-6-59			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/8/59		22c. NAME OF CEMETERY OR CREMATORY ROCKINGHAM		22d. LOCATION (City, town, or county) (State) BERLIN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Anna H. Burbyce ADDRESS Berlin Md				24a. REC'D BY REGISTRAR DATE JUL 10 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

[Faint, illegible text and markings on the certificate form, including fields for name, date, and cause of death.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after this certificate has been signed by the attending physician and completed, may file it with the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, after this certificate has been signed by the attending physician and completed, may file it with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8573

Item 3 Film G244 7-21-59 e t

CERTIFICATE OF DEATH

08550

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> c. LENGTH OF STAY IN It <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Life</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> d. STREET ADDRESS <u>Life</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>May</u> Last <u>Fields</u>				4. DATE OF DEATH Month <u>7</u> Day <u>2</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-77</u>	9. AGE (In years and birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homeless</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Berlin Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Fields</u>			14. MOTHER'S MAIDEN NAME <u>Annie Powell</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Virginia Powell</u> Address <u>Life</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive Heart Failure</u> DUE TO (b) <u>Hypertensive C-V Disease</u> DUE TO (c) <u>5 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Loneliness</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>9-13</u> , 19 <u>57</u> , to <u>7-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-2</u> , 19 <u>59</u> , and that death occurred at <u>3:00 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ivory U. Sully, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin Md</u>			DATE SIGNED <u>7/6/59</u>		
PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr.</u> M.D.		ADDRESS <u>Berlin Md</u>					
22a. BURIAL, CREMATION, (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-6-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cem</u>		22d. LOCATION (City, town, or county) <u>Berlin Md</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. West</u>		ADDRESS <u>Salisbury, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Friend</u>		

CERTIFICATE OF DEATH

1912

1912

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Blank form with horizontal lines for text entry.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute it as soon as possible, and forward it to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. 4 should be forwarded to the Medical Director: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BR 2/57

8574

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin Md Rural</i>		c. LENGTH OF STAY IN 1b <i>1</i> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin, Md</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Walter Roger Harmon</i>		4. DATE OF DEATH Month <i>7</i> Day <i>27</i> Year <i>1959</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-23-1909</i> 9. AGE (In years last birthday) <i>50</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Raising poultry, farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Henry Harmon</i>		14. MOTHER'S MAIDEN NAME <i>Susan Hester Ellen Purnell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>1-1-1-1-1-1-1-1-1-1</i>	
17. INFORMANT <i>Florence Harmon</i>		Address <i>Berlin, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Basal fracture of skull & broken neck</i> DUE TO <i>Backward fall from moving truck to hard surface road</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>824X</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <i>Struck by a log in the moving truck, causing a fall</i>	
20c. TIME OF INJURY Month, Day, Year <i>7-27-59</i> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, shop, office bldg., etc.) <i>Suburban</i> 20f. City or town (County) (State) <i>Berlin, Worcester Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>N.E. Sartorius Jr</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>N.E. Sartorius</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/28/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Peter's Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Near Salisbury Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clinton E. Stewart</i>		ADDRESS <i>Salisbury Md</i>	
24a. REC'D BY REGISTRAR <i>August 4 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

DATE SIGNED

7/27/59

WILLIAM L. BROWN

WILLIAM L. BROWN
MEDICAL EXAMINING CERTIFICATE OF DEATH

0222

1
111
111



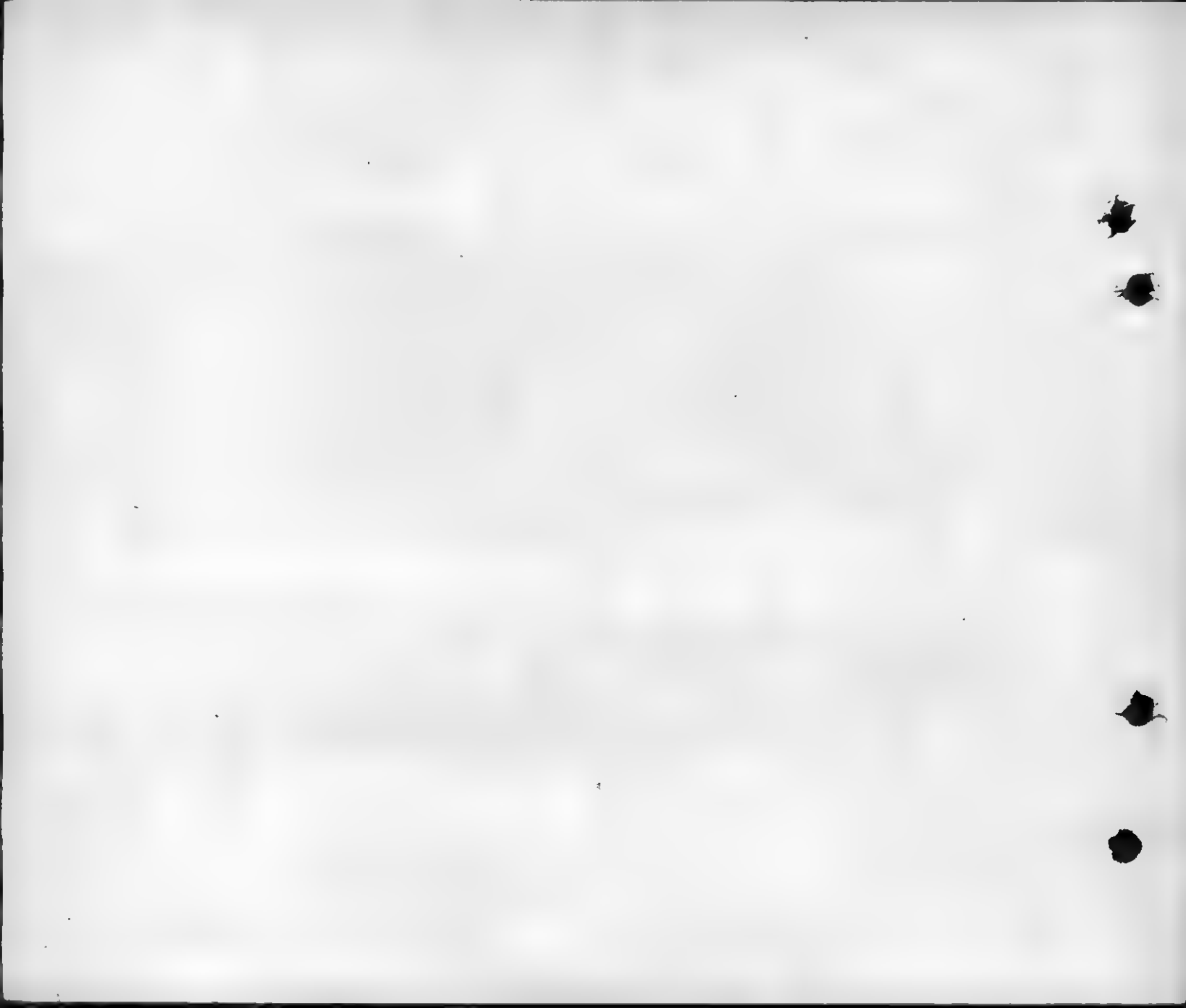
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8575 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118552

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>	c. LENGTH OF STAY IN 1b <u>2 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>		d. STREET ADDRESS <u>11 Main St</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Henry</u> First <u>Long</u> Middle <u>Harrison</u> Last	4. DATE OF DEATH Month <u>7</u> Day <u>4</u> Year <u>19-59</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1 - 1897</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mrs. Harrison farms & fruit grower</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
13. FATHER'S NAME <u>Oslando Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Addie H Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Sec. Employed</u>	
17. INFORMANT <u>Hale Harrison</u>		Address <u>Berlin Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>?</u> (a), stating the underlying cause last. (c) <u>?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Slight abrasion of forehead and nose when fell to floor</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>7-4-59</u> Hour <u>8</u> a.m. <u>0</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City, town, or county) <u>Ocean City</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. E. Sartorius Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. E. Sartorius Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) <u>BERLIN</u> (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>		ADDRESS <u>Berlin Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 10 1959</u>		24b. REGISTRAR'S SIGNATURE <u>C. Stuart S. Kline</u>	



CERTIFICATE OF DEATH

8576

08553

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>NORFOLK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DEL</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLAYMONT</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>		d. STREET ADDRESS <u>23 AVE C-</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>H.</u> Last <u>HONEY</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 22, 1872</u>
9. AGE (In years last birthday) <u>86 5/11</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>5</u> Days <u>17</u> Hours <u>11</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRAINMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PENNS. R. R.</u>	
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH HONEY</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>140</u>	
17. INFORMANT <u>MR. SIMUEL BLAND, CLAYMONT DEL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary Thrombosis sec</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Chronic Degenerative Inflammation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15-30 min</u> <u>3 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 26, 1959</u> , to <u>July 26, 1959</u> , that I last saw the deceased alive on <u>July 26, 1959</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Berlin, Md</u> DATE SIGNED <u>Anna A. Buehler</u>			
ACTUAL SIGNATURE <u>Anna A. Buehler</u> M.D.		PHYSICIAN'S NAME (Type) <u>Berlin, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW</u>	22d. LOCATION (City, town, or county) (State) <u>WILMINGTON DEL</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Buehler</u> ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>JUL 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1, 2, and 3 should be filed, with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

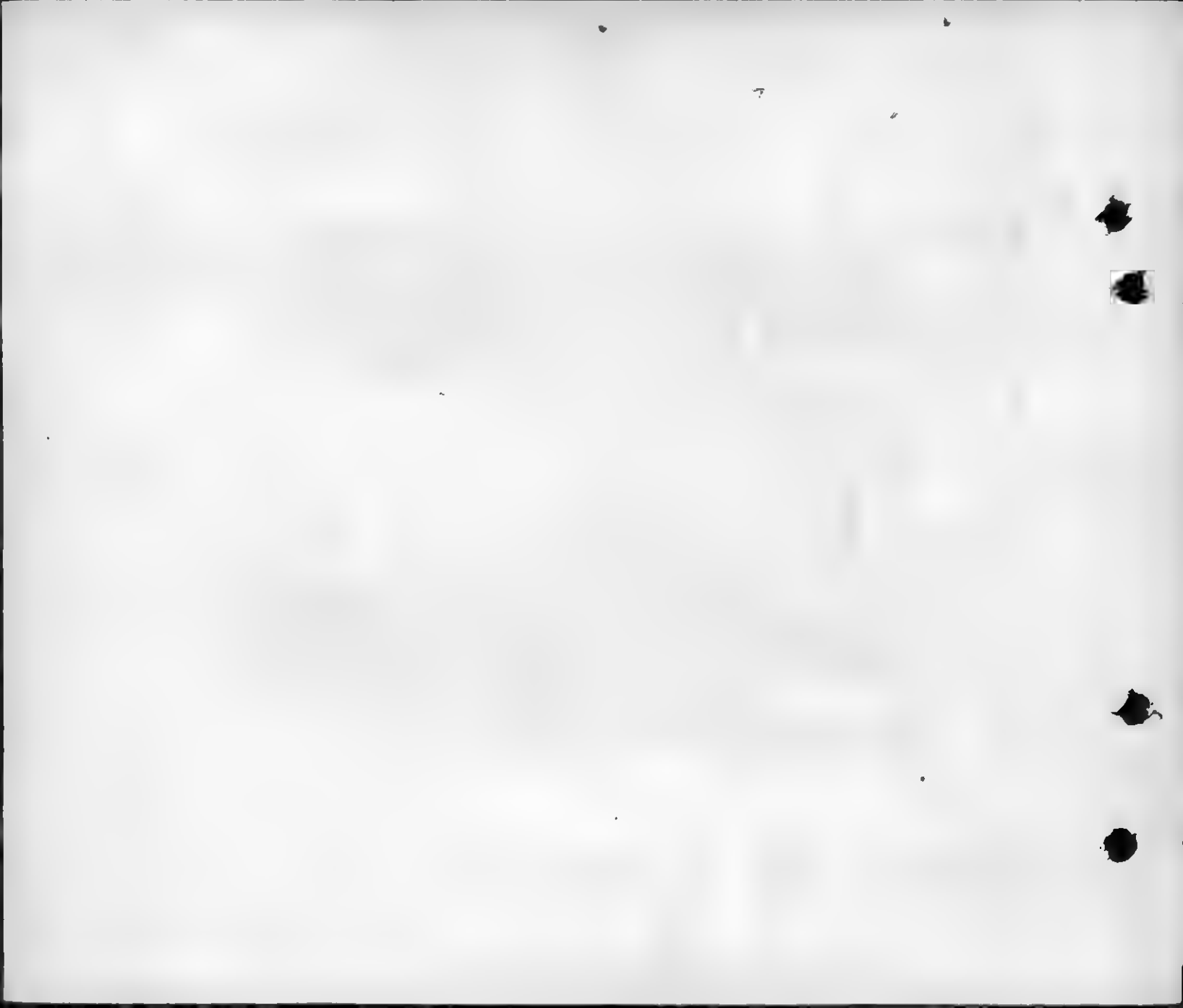
Reg. Dist. No

8577

1 PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Sidney</u> Middle <u>L.</u> Last <u>Hudson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1959</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 8, 1889</u>
9. AGE (In years (last birthday)) <u>69</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken raiser</u>	
11. BIRTHPLACE (State or foreign country) <u>Worcester Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sidney Hudson</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes, give year or dates of service</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Lulu Hudson</u> Address <u>Bishop, Md.</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, transverse colon, c</u> <u>152.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic, bone mets.</u> DUE TO (c) <u>Intestinal Stricture near & above</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs.</u> <u>3 mos.</u> <u>1c day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1959</u> to <u>July 5, 1959</u> , that I last saw the deceased alive on <u>July 7, 1959</u> , and that death occurred at <u>B.P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>7/10/59</u>			
ACTUAL SIGNATURE <u>HERMAN A ROBBINS</u> M.D.		PHYSICIAN'S NAME (Type) <u>HERMAN A ROBBINS M.D.</u>	
22a. BYRIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>July 12, 1959</u>	<u>Old Fellows</u>	<u>Bishopville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Watson</u> ADDRESS <u>Pocomoke City, Md.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>JUL 14 '59</u>	<u>John A. Haines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
INSTRUCTIONS
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and lawfully filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

118555

CERTIFICATE OF DEATH

8578

Reg. Dist. No.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Worcester</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Worcester</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>	LENGTH OF STAY (in this place) <i>—</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>	TOWN <i>Berlin</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <i>RFD # 2</i>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>Ronald</i> (Middle) <i>Johnson</i> (Last)		(Month) <i>July</i> (Day) <i>4</i> (Year) <i>19-59</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>S</i>	8. DATE OF BIRTH <i>7-4-59</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>5 years</i>
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jessie James Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Lillie Mae Corbin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <i>Mother, Berlin, Md</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <i>Neonatal</i>			<i>5 min</i>
ANTECEDENT CAUSE(S) DUE TO (B) <i>Asphyxia</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Obstruction of Airways</i>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Unattended birth</i> , 19 <i>7-4-59</i> , that I last saw the deceased alive on <i>3:25 A</i> , 19 <i>7-4-59</i> , and that death occurred at <i>3:25 A</i> , from the causes and on the date stated above.			
SIGNATURE <i>George R. Sully, Jr.</i>		ADDRESS (Street, city, town, state) <i>Berlin, Md</i>	
DATE <i>7-4-59</i>		DATE SIGNED <i>7-4-59</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		DATE THEREOF <i>7/5/59</i>	
NAME OF CEMETERY OR CREMATORY <i>St. Pauls</i>		LOCATION (City, town, or county) (State) <i>Berlin Md</i>	
24. REC'D BY REGISTRAR <i>Jul 7 '59</i>		REGISTRAR'S SIGNATURE <i>William S. King</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Diana D. Burtage</i>		ADDRESS <i>Berlin Md</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08556

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8579

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>MD</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u> <u>04-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Breakers Hotel</u>				d. STREET ADDRESS <u>100 West End Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Clifford</u> Last <u>KRUGER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 22 1912</u> 47 yrs	
9. AGE (In years last birthday) <u>47</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PAUL KRUGER</u>				14. MOTHER'S MAIDEN NAME <u>EMMA M. VOSSLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Mrs. Mabel Kruger (wife)</u>		Address <u>CAMBRIDGE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION Aorta</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Francis J. Townsend Jr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANCIS J. TOWNSEND JR</u>				DATE SIGNED <u>July 19, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 21, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DORCHESTER MEN. PARK</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LECOMPT FUNERAL SERVICE</u>				ADDRESS <u>CAMBRIDGE MARYLAND</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knapp</u>	
				24a. REC'D BY REGISTRAR <u>July 27 '59</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing it and "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 1 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



8580

CERTIFICATE OF DEATH

08557

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MD b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1 d. STREET ADDRESS WEST ST	
3. NAME OF DECEASED (Type or print) First Middle Last LAURA JANE LITTLETON		4. DATE OF DEATH Month Day Year JULY 25 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 1, 1865
9. AGE (In years last birthday) 93 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM SARMAN		14. MOTHER'S MAIDEN NAME MARY ANNE TIMMONS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO NO	
17. INFORMANT MR. SEWELL LITTLETON		Address BERLIN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive Cardiac failure DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) Severe atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2-3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Seizure			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 25, 1953 to July 25, 1959 that I last saw the deceased alive on July 25, 1959 , and that death occurred at MD from the causes and on the date stated above. ADDRESS (Street, city or town, state) BERLIN, MD. DATE SIGNED 7/27/59			
ACTUAL SIGNATURE Robert G. Grubb M.D.		PHYSICIAN'S NAME (Type) ROBERT A. GRUBB, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/28/59	
22c. NAME OF CEMETERY OR CREMATORY BUCKINGHAM		22d. LOCATION (City, town, or county) (State) BERLIN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Amos A. Burby		ADDRESS Berlin Md	
24a. REC'D BY REGISTRAR DATE JUL 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8581 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

185558

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Dauphin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN 1b <u>24 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisburg</u> <u>701 X</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Boat in Sinepuxent Bay</u>				d. STREET ADDRESS <u>707 Mountain Rd</u>		e. IS RES. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Arthur Luckett</u> First Middle Last				4. DATE OF DEATH <u>July 13 1959</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 14 1894</u>	9. AGE (In years last birthday) <u>64</u> yrs.	1f. UNDER 1 YEAR Months Days Hours Min.		1g. UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Scotland Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Luckett</u>				14. MOTHER'S MAIDEN NAME <u>Emma Deitrich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>207-07-9869</u>		17. INFORMANT Address <u>707 Mountain Rd Harrisburg Pa</u> <u>Mrs Lucille Hall, daughter</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic (C.V.D.)</u> (c) <u>24 years</u> DUE TO <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Francis J. Townsend Jr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>July 13, 59</u>	
EXAMINER'S NAME (Type) <u>Francis J. Townsend Jr</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EAST HARRISBURG</u>		22d. LOCATION (City, town, or county) (State) <u>HARRISBURG PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anne A. Burbage</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Francis</u>			

MEDICAL CERTIFICATE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing it and "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.



8582

CERTIFICATE OF DEATH

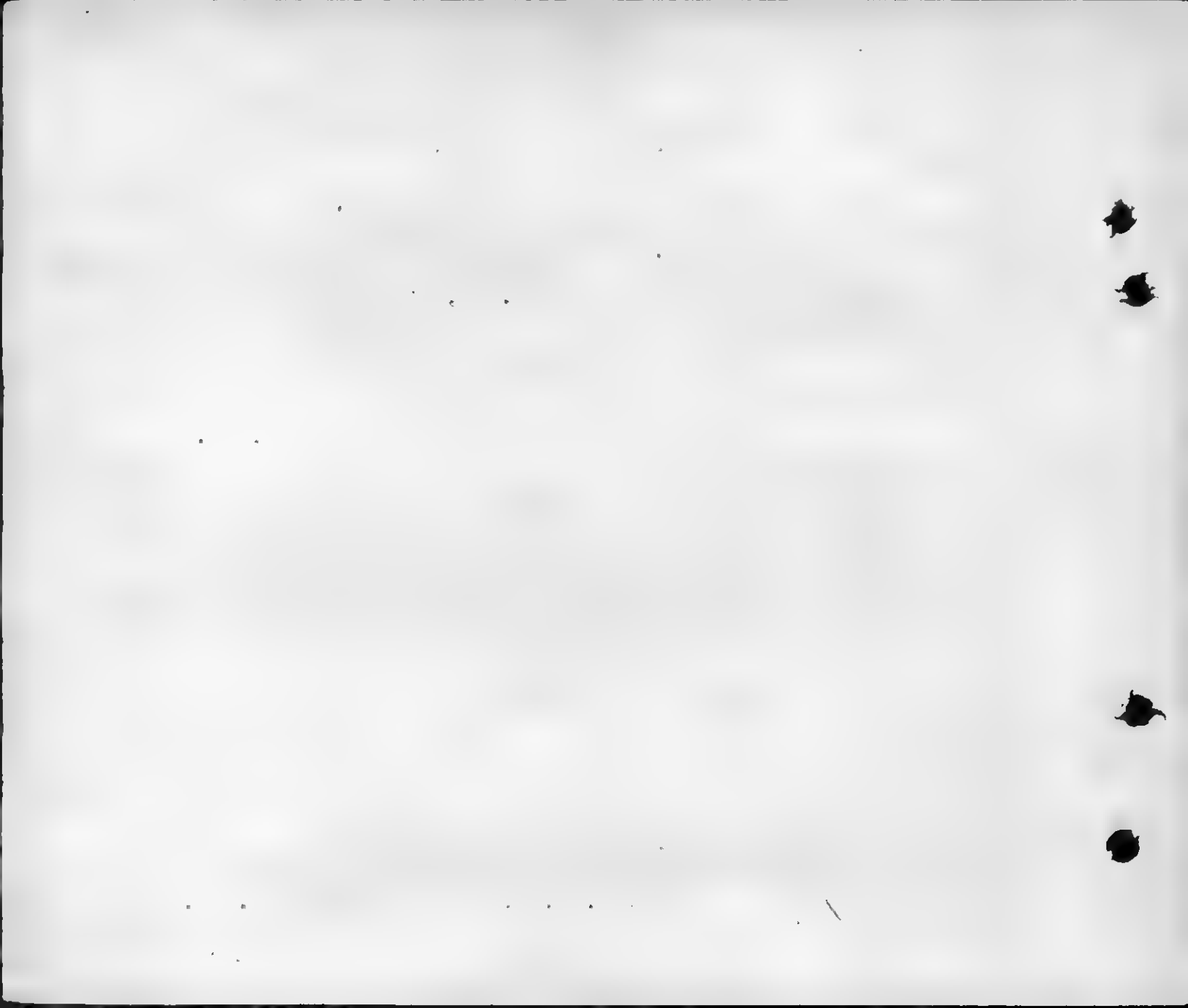
08559

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin				c. LENGTH OF STAY IN 1b 39yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXXX				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin			
d. STREET ADDRESS North Main St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK Middle A. Last MAGEE				4. DATE OF DEATH Month July Day 13 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 18, 1875	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Oil Distributor			
11. BIRTHPLACE (State or foreign country) Delaware				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Arthur Magee				14. MOTHER'S MAIDEN NAME Laura Birch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> If yes, give war or dates of service				16. SOCIAL SECURITY NO. Raymond Magee		17. INFORMANT Berlin, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) sudden myocardial failure DUE TO possible coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: extensive arteriosclerosis (b) 15 min (c) 1/2 hour PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from May 1954 to July 13, 1959 , that I last saw the deceased alive on July 13, 1959 , and that death occurred at 12:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Robert A. Grubb M.D. BERLIN, Md. 7/14/59 PHYSICIAN'S NAME (Type) ROBERT A. GRUBB.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/15/59		22c. NAME OF CEMETERY OR CREMATORY I. O. O. F.	
22d. LOCATION (City, town, or county) (State) Bishopville, Md.				24a. REC'D BY REGISTRAR DATE JUL 16 59			
24b. REGISTRAR'S SIGNATURE Robert A. Grubb							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8583

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Northampton</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural</u>	c. LENGTH OF STAY IN 1b <u>✓</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wardtown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Route 113</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>John Wm. Mapp</u>		4. DATE OF DEATH <u>July 31 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7 1937</u>
9. AGE (in years, months, days) <u>21 9 54</u>		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V.P. College</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>Virginia</u>	
13. FATHER'S NAME <u>Harry P. Mapp</u>		14. MOTHER'S MAIDEN NAME <u>Ortha Cisher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>25-48-1334</u>	
17. INFORMANT <u>Mr. Harry P. Mapp</u>		Address <u>Wardtown Virginia</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u>			
DUE TO (b) <u>TRAUMA</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>TRUCK COLLISION</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURE LEFT HUMERUS & FRACTURE RIGHT TIBIA</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>TRUCK COLLISION US 113 3 MILES N. of SNOW HILL</u>	
20c. TIME OF INJURY Month, Day, Year <u>7/31 1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U.S. 113</u>	20f. (City or town) <u>SNOW HILL</u> (County) <u>WORCESTER</u> (State) <u>MD.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Robert C. LaMar</u>		DATE SIGNED <u>7/31/59</u>	
EXAMINER'S NAME (Type) <u>Robert C. LaMar</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial Aug. 2/59</u>	22b. DATE THEREOF <u>Aug. 2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belle Haven Cemetery</u>	22d. LOCATION (City, town, or county) <u>Belle Haven, Virginia</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton E. Dammis</u>		24. REC'D BY REGISTRAR <u>AUG 3 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Clayton E. Dammis</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Every delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Level Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8584 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08561

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill, Md</u>	
c. LENGTH OF STAY IN 1b <u>4 years</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENT ON A FARM. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Andrew</u> Middle <u>Parker</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 23-1958</u>
9. AGE (In years last birthday) <u>6</u> yrs. <u>17</u> Months <u>6</u> Days <u>17</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Snow Hill, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Lee Parker</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Watkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Sarah Elizabeth Watkins</u> Address <u>Snow Hill, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (probably)</u> 7-3 X DUE TO (b) <u>Cold + Malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hydrocephalus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>N. E. Sartorius</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/19/59</u> (State) <u>Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Whitaker Cemetery</u>		22d. LOCATION (City, town, or county) <u>Snow Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Gunn</u> ADDRESS <u>Snow Hill, Md</u>		24a. REC'D BY REGISTRAR <u>13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8585

Item 8 Film 6244 7-21-59 et

CERTIFICATE OF DEATH

08562

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Girtletree		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Girtletree	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1		e. STREET ADDRESS R.D.# 1	
3. NAME OF DECEASED (Type or print) First MILLIE Middle PARSONS Last PARSONS		4. DATE OF DEATH Month JULY Day 12th Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1880
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY Wisconsin	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Farington		14. MOTHER'S MAIDEN NAME -(Unk)	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Asbury Parsons (Husband) R.D.# 1 Girtletree, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-Vascular Accident 331X DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 20 min 5 yrs			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 1958 to July 1959 that I last saw the deceased alive on May 15, 1959 , and that death occurred at 9:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED July 14/1959 ACTUAL SIGNATURE John M. Bender M.D. PHYSICIAN'S NAME (Type) Dr. John M. Bender 215 W. Martin St. Snow Hill, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial- July 15, 1959	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR DATE JUL 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

8586

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG246 7-31-59 et

08563

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MA</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		4. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>John Francis Parnell</u>		4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-1914</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>13</u>	
10a. USUAL OCCUPATION (Give last work done during most of working life, even if retired) <u>Chicken Poultry</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Elmer Dixon</u>		14. MOTHER'S MAIDEN NAME <u>Kate Parnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>222-12-1047</u>	
17. INFORMANT <u>Mary Parnell</u>		Address <u>Berlin</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
<u>47</u> DUE TO <u>Coronary Artery Disease</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE DISEASE CONDITION GIVEN IN PART I (a)			
<u>Serious Asthmatic Symptoms with severe anginal</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>N. E. Sartorius</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/19/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>July 22-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sarah Dukes Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin MA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>Pocomoke Md</u>	
24a. REC'D BY REGISTRAR <u>Jul 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8587 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18564-

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City Rural</u> c. LENGTH OF STAY IN 1b <u>100 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>None</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> d. STREET ADDRESS <u>R 28</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Leah</u> Last <u>Turner</u>		4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1891</u> 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lynwood</u>		14. MOTHER'S MAIDEN NAME <u>Leah</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-560</u> 17. INFORMANT <u>Woodward</u> Address <u>Pocomoke</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO <u>Pneumonia (lobar)</u> <u>refort</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>DK</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. 19 <u> </u>		20d. INJURY OCCURRED <u> </u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
ACTUAL SIGNATURE <u>N. E. Dextorius</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/7/59</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Dextorius</u>		22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>7-12-59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Hall's Hill</u> 22d. LOCATION (City, town, or county) <u>Pocomoke, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> DATE <u>JUL 15 '59</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your office. File pages 1 and 2 with the registrar for burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1g. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8588

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18565

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Street - 20th & Baltimore Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>KIRKE</u> First <u>Whitehouse</u> Middle <u>Wales</u> Last				4. DATE OF DEATH <u>JULY 8</u> Month <u>8</u> Day <u>1959</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 3, 1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>12</u>		IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter, Retired Building</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Nanticoke Md</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John William Wales</u>				14. MOTHER'S MAIDEN NAME <u>Jelly Anne Douglas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217010964</u>			
17. INFORMANT <u>Mabel Wales</u> Address <u>Nanticoke Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion Acute</u> DUE TO <u>Arteriosclerotic (CVD)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 years.</u> DUE TO (c) <u>Instant.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Francis J. Townsend Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANCIS J. TOWNSEND JR. ASST.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nanticoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Messing, Bishop, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE <u>7/13/59</u></u>		24b. REGISTRAR'S SIGNATURE <u>C. H. Messing</u>	

MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8589 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08566

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Earl</u> <u>Harrison</u> <u>Waples</u>		4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 28-1933</u> 25 yrs
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Worcester</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Benjamin Waples</u>		14. MOTHER'S MAIDEN NAME <u>Kella C. Potts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>217-30-8245</u>	
17. INFORMANT <u>Mr F H Waples</u> Address <u>Berlin Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nightfall Skull fractures with</u> <u>fracture of jaw & hemorrhage</u> DUE TO <u>Auto accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auto accident</u> DUE TO (c) <u>Auto accident</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dr. J. J. Waples, M.D.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>After leaving hospital at 4:00 PM</u>	
20c. TIME OF INJURY Month, Day, Year <u>7-25-59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, etc.) (City or town) (County) <u>Berlin Md Worcester</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>N. E. Sartorius</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry Watson</u> ADDRESS <u>Re Delby</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 29 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, and the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

